

Institute on Mental Deficiency

November 22-24, 1948

UNIVERSITY OF MINNESOTA
CENTER FOR CONTINUATION STUDY
MINNEAPOLIS 14, MINNESOTA

48-1MD-00M

Institute on Mental Deficiency, University of Minnesota.

Institute on Mental Deficiency

November 22 - 24, 1948

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University of Minnesota.
Center for Continuation Study.
Minneapolis 14, Minnesota

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PREFATORY NOTE

The Institute on Mental Deficiency held November 22, 23, and 24, 1943, at the University of Minnesota Center of Continuation Study was presented with the cooperation and support of the Minnesota Division of Public Institutions and the Minnesota Department of Health.

11/24/43, 11/25/43, 11/26/43

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UNIVERSITY OF MINNESOTA
Center for Continuation Study

-i-

Institute on Mental Deficiency

November 22 - 24, 1948

Program

Monday, November 22

Presiding: Mildred Thomson

8:15 - 8:45 Complete registration. Dormitory Desk, Center for Continuation Study

8:45 - 9:00 Introduction.....William Griffiths, C. J. Jackson, J. M. Holte

9:00 - 12:00 Forum - What is Mental Deficiency?

Education - Lettisha Henderson, Supervisor of Special Classes, St. Paul Public Schools

Social Work - Joe Ann Kramer, Psychiatric Social Worker, Youth Conservation Commission

Psychology - Harriet Blodgett, Psychologist, Institute of Child Welfare

Psychiatry - Walter P. Gardner, M.D., Psychiatrist, previously Superintendent of Anoka State Hospital

Law and the Court - Judge Gustavus Loevinger, State of Minnesota, District Court, Second District.

(Each presentation limited to 25 minutes. Discussion follows.)

12:00 - 1:00 Luncheon. Center dining room

Presiding: Mildred Thomson

1:00 - 4:30 Forum - What the Community Oves to the Mentally Deficient

The Family - R. T. Lindh, President, Friends of Mentally Retarded Children (15 min.)

The School - Clara Thorpe, County School Superintendent, Yellow Medicine County (15 min.)

The Church - Harold Belgum, Assistant Executive Secretary, Lutheran Welfare Society

The Public Health Nurse - Ruth von Bergen, Mental Hygiene Nursing Consultant, State Board of Health (15 min.)

The Physician or Psychiatrist - Reynold Jensen, Associate Professor of Pediatrics, University of Minnesota (30 min.)

The Social Worker - Frances Coakley, Social Worker, Bureau for Mentally Deficient and Epileptic (30 min.)

Tuesday, November 23, 1948

Trips to the School for Feeble-minded at Faribault and to the Owatonna State School at Owatonna.

Discussion of programs by:

E. J. Engberg, M. D., Superintendent, Faribault

M. R. Vovle, Superintendent, Owatonna

Wednesday, November 24

Presiding: William Ferguson

8:15 - 9:00 The Colony for Epileptics - R. J. Gully, M.D., Superintendent, Cambridge

9:00 - 9:45 The Annex for Defective Delinquents - Ralph Rosenberger, Education Director, State Reformatory, St. Cloud

9:45 - 10:30 Legislation and Additional Facilities Needed - Carl J. Jackson, Director, Division of Public Institutions

10:30 - 11:30 Summary

Registrants

Allen, Florence J.	Glencoe, Minnesota
Anderson, Lulu T.	Granite Falls, Minnesota
Anderson, Marjorie	Chisholm, Minnesota
Andrews, M. Evelyn	Minneapolis, Minnesota
Blaha, Helen	Pipestone, Minnesota
Bogenrief, Kathryn	Thief River Falls, Minnesota
Bormann, Dolores J.	Breckenridge, Minnesota
Bright, Sumner S.	Luverne, Minnesota
Broderick, Amy	Preston, Minnesota
Buirge, Margaret C.	Pine City, Minnesota
Burns, Elizabeth	Wheaton, Minnesota
Gammack, Gertrude E.	St. Paul, Minnesota
Coleman, Esther	Hallock, Minnesota
Daniels, Maxine E.	Crookston, Minnesota
Ditlevson, Lloyd W.	South St. Paul, Minnesota
Dobel, Pearl	Blue Earth, Minnesota
de Waard, Nancy	Winona, Minnesota
Dorn, Olga F.	Cambridge, Minnesota
Eaton, Jo Anne	Rochester, Minnesota
Erickson, Maurine	Stillwater, Minnesota
Erickson, Pearl R.	Roseau, Minnesota
Fish, Patricia V.	Milaca, Minnesota
Fisher, Donald F.	Waseca, Minnesota
Firssell, Georgia	Warren, Minnesota
From, Raymond	Baudette, Minnesota
Fuller, Pearl	Redwood Falls, Minnesota
Gambrino, Frances	St. Cloud, Minnesota
Gannon, Irene M.	Glenwood, Minnesota
Gee, Adelaide	Hibbing, Minnesota
Glas, Esther L.	Litchfield, Minnesota
Hageseth, Robert S.	Austin, Minnesota
Harrison, Frank L.	Walker, Minnesota
Hartfiel, Lillian	Park Rapids, Minnesota
Hartman, Florence L.	Albert Lea, Minnesota
Henjum, Signe V.	New Ulm, Minnesota
Holmberg, Earl C.	Minneapolis, Minnesota
Hooker, Gerald W.	Long Prairie, Minnesota
Jacobson, Irene H.	Gaylord, Minnesota
Kennedy, Kenneth J.	Maple Lake, Minnesota
Langeberg, Rhoda	Winona, Minnesota
Lemke, Mabel	Chaska, Minnesota
Leonard, Mary Elizabeth	St. Cloud, Minnesota
Lieb, Helen M.	Faribault, Minnesota
Luiten, X. E.	Grand Rapids, Minnesota
Martinson, Ruth C.	Worthington, Minnesota
Meland, Frances F.	Mound, Minnesota
Millard, Harriet	Aitkin, Minnesota
Myller, Hazel	Moorhead, Minnesota
Nupson, Alta	Redwood Falls, Minnesota
Nygren, Bertha	Carlton, Minnesota
Olson, Merrilyn L.	Lindstrom, Minnesota
O'Rourke, Grace W.	Duluth, Minnesota

WHAT IS MENTAL DEFICIENCY? FROM THE VIEWPOINT OF EDUCATION

Lettisha Henderson

Prior to the latter part of the 19th Century the schools had relatively little cause to be concerned with the problem of mental deficiency, since the force of natural selection took care of the element of survival in the academic world. Those children unable to compete with their peers seldom continued very long in school. Many just did not present themselves for admission.

However, with the introduction and extension of the compulsory education laws in the various states and the consequent effecting of our American policy of educating all children in the community, the school authorities were confronted with a highly diversified population with wide ranges in individual differences. Looming prominently in the group with extreme deviations were those children who were primarily characterized by their "backwardness."

This intellectual "backwardness" in some children constituted such a problem to the administration and to the organization of the school program that many had to be excluded from school. Others were permitted to remain to mark time or to be subjected to the pressure of school requirements which they were not able to meet.

At the turn of the century a few day school classes for academically retarded children made tentative beginnings in the development of specialized programs for the group with marked retardation. These programs began in the more highly populated areas, because of the incidence of cases of very evident "backwardness" - overage for the school grade, inability to learn, behavior problems in the classroom, continual failure.

Educators, on the whole, have been slow to realize that these difficult backward children were mentally deficient - that they could not learn, not that they would not learn as normal children. With the recognition of the problem of mental deficiency came the development of special education to take care of the educational needs of this group of children. Nowhere is this educational service extensive enough to offer educational opportunity for all the mentally retarded, even in school systems with well established programs.

The experience of school people with mental deficiency has yielded some pertinent information to school work. Mental deficiency is characterized by a slow rate of learning, inability to do the work prescribed, general social incompetence.

In the school population, the degree of differentiation and mental capacity was found to be a continuous one, with most children falling within the normal or average range and with variations ranging from high average to genius, on the one hand, and on the other, with slow children varying from low average to the lowest degree of social and intellectual incompetency. There was no point of sharp cleavage between the normal group of children and the retarded group. With the beginning of scientific studies of individual differences around 1904 - with the development of the Binet Tests for individual mental examinations - investigations established some important facts: - one, the statistical frequency of the occurrence of the normal or average in degree of intelligence, of the above normal, of those below normal. The group of children of school age designated as mentally retarded constitutes about two to five percent of the population.

Through the administration of objective mental tests it became possible to identify the mentally retarded upon entrance at school without waiting for them

Otness, Dorothy
Palmer, Frank R.
Pederson, Margaret
Ramshaw, Charlotte
Rilling, Ruth
Rossi, Marie D.
Sauve, Viola
Schultz, Nina L.
Stahl, Lucille
Stevens, Margaret B.
Stocking, Ruth
Strand, Angeline V.
Sundberg, Mary Laura
Swanger, Florence
Uldrich, Evelyn
Umumb, Mary E.
Uttech, Eileen
Van Selus, Emma M.
Verkennes, John H.
Warnick, Dorothy J.
Wilcox, Kathryn
Windland, Lorraine T.
Winterfeldt, Roland F.
Wolf, Gordon L.
Vehle, Delia
Zehnle, Julia
Ziegler, Mildred

Minneapolis, Minnesota
Minneapolis, Minnesota
Jackson, Minnesota
Bemidji, Minnesota
Willmar, Minnesota
Two Harbors, Minnesota
Red Lake Falls, Minnesota
Mantorville, Minnesota
Windom, Minnesota
Marshall, Minnesota
Detroit Lakes, Minnesota
Wabasha, Minnesota
Fairmont, Minnesota
Dawson, Minnesota
Little Falls, Minnesota
Alexandria, Minnesota
Gaylord, Minnesota
Granite Falls, Minnesota
Shakopee, Minnesota
St. James, Minnesota
Mantorville, Minnesota
New Ulm, Minnesota
Olivia, Minnesota
Brainerd, Minnesota
Ada, Minnesota
Long Prairie, Minnesota
Mora, Minnesota

to demonstrate their inability to handle the school program.

The individual mental testing program led to the development of another service in the school system - psychological service - one of the purposes of which was the identification of cases for these special educational programs. This psychological service, as well as the service of special education, is a relatively costly one, so that its extension has lagged behind the need.

School systems are somewhat inclined to categorical group distinctions in considering mental retardation. Educators accept the fact that mental tests measure individual differences in degree only. Their general practice is to define the problem in terms of intelligence quotient for functioning purposes of administration. In those systems where special education programs are established, children are eligible with I.Q.'s within a certain limit. The upper limit generally varies from 70 to 80 - most usually at 75, some as low as 65. The lower limit varies somewhat also, with the usual limit at 50.

In Minnesota the State Program for mentally retarded classes defines the range of I.Q. at 50 to 80, both inclusive. Some programs are established in this state by local communities for children with I.Q.'s below 50 - but without state recognition for state aid or for standards of instruction, organization, or administration. Whatever standards prevail in a state or in a local community for special classes for subnormals more or less determine the identification of that group in the school community. Children who fall below that arbitrary classification are popularly considered by school people proper candidates for institutional placement.

While educators think of mental deficiency in terms of objective measurement - the intelligence quotient - they also consider the problem in terms of observed educational ability and of performance, in terms of horizontal as well as of vertical learning, in terms of intellectual growth and maturation, in terms of disabilities - lack of adequate reasoning and of good judgment - lack of ability to adjust to situations.

Educators, especially in the field of special education, are concerned with what a mentally deficient child can learn, what his individual differences are, what his special abilities may be, what the prognosis is of those in this classification and of the individuals within the group in terms of educational accomplishment.

Kuhlman's research has been very enlightening in the understanding of the problem of mental deficiency, especially since there was an earlier tendency on the part of some of the people in the field to consider mental deficiency as arrested development. His study of institutional children over a ten year period indicated a continuous mental inferiority for the group and a predictability of the mental level of growth at maturation. A child with an I.Q. of 50 at maturity will probably not exceed the average mental ability of an average eight year old, while a child with an I.Q. of 75 at maturity can probably be expected to attain at the maximum the mental ability of an average twelve year old.

In the early school programs for the mentally deficient, it was thought that the intellectual failure of this group to achieve normally at the chronological age level indicated lack of ability for success in any academic program. Many programs of handwork were instituted to keep these children busy. A great deal more is now known of the individual differences and especially of other factors than intellectual capacity that have a bearing on the development of these individuals.

It is fallacious to assume that further learning ceases at maturity for these

individuals or that further learning in any case ceases at full mental development. The degree of mental development is the point of consideration - horizontal learnings continue.

In conclusion, individual mental examinations and other psychological scales remain the best objective standards of determining mental ability. More important than the ratings per se are the interpretations of the findings, inasmuch as the limitations and the construction of the various testing instruments need to be understood. It should also be pointed out that the tests themselves are constantly being improved. While research has yielded much of significance to the concept of mental deficiency, there is still much that remains unknown.

WHAT IS MENTAL DEFICIENCY? FROM THE VIEWPOINT OF THE SOCIAL WORKER

Joe Ann Kramer*

The social worker has the responsibility of approaching the problem of mental deficiency from all different angles. She is interested not only in the total individual but in his reactions to his environment. The social worker is interested in an all-inclusive diagnosis of mental deficiency. The individual must be studied within his own setting and his adjustment must be evaluated in terms of his culture.

The social worker must coordinate all information available to determine the proper level of functioning of an individual. The diagnosis of mental deficiency would seem to indicate consistently slow progress. Some of the points to be considered in determining the mental level of a child are:

a. How does this child's development correspond with the development of a normal child? Illness may retard growth; however, it has been found that a child who has been ill catches up with the development of normal individuals with great rapidity following recovery. The developmental history of the first year of life is most important.

b. What learning opportunities have been available for this child? Example: Why does this child play with younger children? Don't jump to conclusions. The child may not have had an opportunity to play with other children. The parents may have prevented companionship by restricting the selection of playmates.

c. Has there been any emotional blocking?

d. What has been the child's school adjustment?

Is there a hearing defect?

Is there a visual defect?

Is the child a non-reader?

Is the child pre-occupied with his own problems? This may be a reflection of emotional strain within the home.

Before the diagnosis of mental deficiency is made the social worker should investigate all other possibilities for blocking within the mental process.

Sixteen percent of the youths committed to the Youth Authority had I.Q.'s below 90 and eleven percent had I.Q.'s of 110 or above. The retarded child needs protection, and the retarded child is more likely to be caught following a delinquency than the brighter child. Frequently, the retarded youngster is not accepted by his playmates and is excluded from their activities. To gain approval the mentally deficient sometimes reverts to delinquent acts. The mentally deficient have the same needs and feelings as the normal individual.

*From notes taken by Frances Coakley

WHAT IS MENTAL DEFICIENCY? FROM THE VIEWPOINT OF PSYCHOLOGY

Harriet Blodgett

I. The relationships between the work of various disciplines:

In the earlier days of studying mental deficiency, each discipline tended to have one point of view peculiarly its own, and we heard of the medical viewpoint, the psychological viewpoint, the social work viewpoint, the educational viewpoint, etc. With increased knowledge and experience and with improved techniques in all of these fields, the tendency has been to move in the direction of a single viewpoint toward the subject of mental deficiency, and that viewpoint incorporates contributions from all of the various fields. With this progress it has become possible for all the fields to achieve greater interrelation of their thinking.

II. The role of the psychologist:

One arena has remained the special function of the psychologist--test administration and interpretation. The psychologist's interest is in objective studies, including both quantity and quality of the individual's intelligence, and also including another very important aspect--the individual's ability to make use of what capacity he has, how well he can take a place in society and what place is most suitable for him to take.

1. Test procedures:

- a. The importance of training in administration and interpretation.
- b. Use of more than one test for diagnosis. A series of tests provides a better measure than one test by itself.
- c. Use of more than one kind of test for diagnosis: intelligence exists in various areas and is shown and used in various forms of expression. Most commonly defined as verbal or abstract, mechanical, and social. Each of these can be measured to some extent, although probably not perfectly; we have more measures of abstract intelligence and we know more about their use, but progress is being made in the concrete or mechanical and in the social areas, and it is important that it continue to be made by further research on both the measuring instruments we now have and those which may be developed in the future. Especially in the borderline and moron ranges, actual ability is only part of the picture of studying the individual.
- d. Knowledge of the case history: developmental history is especially important for children; educational history, work adjustment, and knowledge of social behavior need to be known in considering the status of adults. Knowledge of family background is important in making predictions of future status of individuals.
- e. The psychologist is perhaps in the best position to study the degree of defect, although it is the physician who is interested especially in classifying the form and type of defect. Degree of defect is indicated by the IQ and by the classification as moron, imbecile, or idiot. These classifications are man-made for purposes of administrative convenience rather than inherent in the nature of the defect; actually, abilities are distributed along a continuum, and our points of division are purely arbitrary and for our convenience.
- f. Integrating separate measurements of the individual into a picture of him

as a functioning person involves personality study and attempts to see potentialities as well as liabilities. Not just what he cannot do, but what he can do acceptably is important in planning. Kanner's concept consists of a "meliorative" viewpoint--improving the situation as much as possible, through training and supervision, rather than thinking in terms of either complete hopelessness or of complete cure.

- g. Because of his training in objective evaluation, the psychologist is in a good position to see each case as an individual pattern of development and response. Because he is frequently more of an outsider in the situation, he is in a position to evaluate the situation without prejudice. In each case, his responsibility is two-fold: what is the best solution for the individual? and what is the best solution for society?

III. The educational role of the psychologist:

The more psychology advances, the more of a specialty it becomes; it is impossible for non-psychologists to be experts in all branches of diagnosis and prediction. An important part of the psychologist's role is to interpret not only his findings but to some extent the bases on which they are made. The courts, lawyers, social workers, and citizens need to know something of how tests are built in order to be able to accept and understand the results. For different cases, the special information needed will vary: for some, it may be an explanation of why the IQ has not remained constant for a period of 10 or 15 years; for others, it may involve discussion and explanation of discrepancies between scores obtained on different tests. For most cases, there needs to be some explanation of why tests work, how items are selected, how they are standardized, how scoring standards are set up, and the like.

WHAT IS MENTAL DEFICIENCY? FROM THE VIEWPOINT OF THE PSYCHIATRIST

Walter Gardner*

In the field of mental deficiency there has been a lack of sufficient research, with Massachusetts being the only state with a research project. In England articles seem to be advocating expansion of research in this field.

I. Psychiatric aspects of definition:

Green of the Fernald School defines a mentally deficient individual as one who has a mental defect to such an extent that he is prevented from competing on equal terms with the rest of the community. The defect is such that he is unable to make a normal social adjustment.

II. Etiology:

1. Gene determined or hereditary 5 to 8 per cent of the mentally deficient
2. Somatic factors which are those factors in the environment after cell conjugation.
 - a. Congenital conditions which are present at birth or from birth such as toxic conditions.
 - b. Natal factors which are due to the birth process such as trauma and lacerations.
 - c. Developmental disorders occurring up to the fifth or sixth year of life such as encephalitis, trauma, or head injury.
 - d. Precipitating factors such as lack of training, poor standards of the family, and emotional attributes.

III. Levels of mental deficiency:

1. Idiot--Those individuals with a mental age up to two years and an I.Q. up to 25. These individuals lead a vegetating existence.
2. Imbecile--those individuals with a mental age from three to seven years with I.Q. ranging from 25 to 50. This group makes up from 12 to 18 per cent of the mentally deficient classification. These individuals are able to protect themselves and some are able to do simple routine work.
3. Moron--those individuals with mental ages from seven to twelve with I.Q.'s from 50 to 70. There are three times as many in this group as in the other two groups of mentally deficient. These individuals are able to do routine tasks and have fewer physical stigmata than the other two groups. They are lacking in judgement and are able to do unskilled and sometimes semi-skilled work.
4. Borderline--those individuals with I.Q.'s from 70 to 85.
5. Dull normal--those individuals with I.Q.'s from 80 to 95.
(The latter two groups are often special school problems or delinquent.)

IV. Medical classifications--these classifications are based on pathological findings:

1. Amaurotic.
2. Mongolism.
3. Hydrocephalus.
4. Cretinism.
5. Paralytic--such as cerebral palsy.
6. Epilepsy of the idiopathic type.
7. Syphilis, which is a much overrated cause of mental deficiency.
8. Undifferentiated types which are gross and obvious.

V. Areas in recognition of the mentally deficient:

1. Developmental history is most important. Slowness of development can usually be seen from shortly after birth. Knowledge of the development of a normal individual is important. The normal child develops as follows:

4 months--child holds head up
6 months--rolls from his side to his back
9 months--sits
12 months--steps
18 months--walks alone

Development of speech

Early weeks--crying
4 months--sounds are vocalized
9 months--says ma-ma
12 months--three words
18 months--five words associated with persons and objects

Pre-school development

Has accomplished training in personal habits
Has knowledge of family structure
Vocalizes for simple conversation
Has a degree of personal responsibility
Responds to authority

2. The rate and pattern of development is important as well as the level of development. A child may develop in his years with a change in rate and pattern occurring later due to organic factors such as head injuries and encephalitis.
3. Activities may point to basic deficiencies.
4. Education--The following difficulties may be relieved by proper school adjustment:

- a. In school the child may react to strain through personality disorders, depression, or delinquency.
- b. Child may be pre-occupied, as shown by day dreaming and fantasy or he may be restless, mischievous, and a truant.
5. Employment of the mentally deficient is characterized by frequent changes, low pay, being the first laid off when there is a slack season, lack of advancement, and nervousness as additional responsibility is placed upon the individual. Public relief is frequently necessary for the mentally deficient who are unable to make a satisfactory work adjustment.
6. Marital and sexual difficulties.
7. Emotional immaturity.

VI. Conditions resembling mental deficiency:

1. Sensory defects such as those of vision and deafness. In speech there is frequently much variability since in some families delayed speech is a familiar trait.
2. Congenital word blindness-- have a specific reading disability.
3. Word deafness.
4. Emotional disorders due to environment, such as restlessness, enuresis, lying, stealing, truancy.
5. Psychopathic personalities which are a constitutional inferiority and may be inherited, congenital, or acquired early in life. Characteristics of this defect are inability to see and understand the rights of others and to profit by experience. Simple schizophrenia and simple depression may be mis-identified as mental deficiency. The work pattern of such individuals is frequently the same as that of the mentally deficient.

VII. Value of psychological testing:

Psychological testing determines the degree of mental deficiency. Standardization of mental tests has meant greater accuracy in diagnosis. Mental deficiency should be worked upon as a complex total problem involving the total behavior factor of an individual.

* Written from notes taken by Frances Coakley

WHAT IS MENTAL DEFICIENCY? FROM THE VIEWPOINT OF LAW AND THE COURT

Gustavus Loevinger

At the outset it is important to keep in mind the statutory definition of the mentally deficient. This definition involves three points:

- a. The patient must actually be proved to have a retarded or defective mentality
- b. He must be shown to be so deficient mentally as to require supervision, control, or care.
- c. It must be shown that such supervision, control, or care is necessary either for the welfare of the patient himself or the public welfare.

Before a court would be willing or justified to render a judgment that a patient was in fact mentally deficient, it would be necessary that the evidence be sufficient to establish all three of these conditions.

In order that a case may be properly in court and proof against jurisdictional attacks, it is necessary that a petition be filed by someone qualified under the law. The County Attorney can be relied upon to prepare a petition in an appropriate case. It is further necessary to make certain that notice of the hearing to be held is properly given to the patient. This provision recently passed upon in the Wretling case is a very salutary and important safeguard to prevent anyone from being "railroaded" into a guardianship. The less able the patient is to take care of himself the more important is it that proper steps be taken to protect his rights. If the patient is unable to employ an attorney, then the court should appoint an attorney to represent him. Care should also be taken that a guardian ad litem be appointed for the patient in the event he has no general guardian. If he is a minor, then notice to his parents might be sufficient provided they are not the ones who are seeking to have him adjudicated. In addition to the petition, the notice, proper representation by a guardian and by an attorney, it is, of course, necessary also to have sufficient evidence to establish the claim of mental deficiency.

The burden of proof is upon the person who alleges that the patient is mentally deficient. By burden of proof is meant that the evidence in favor of the claim of mental deficiency outweighs in its convincing power the evidence against that claim. It does not refer to the number of witnesses nor to the quantity of the evidence but to its convincing quality. The Supreme Court has said that it is not necessary that the evidence be of the cogency commonly referred to in court as "clear and convincing". And, of course, it is not necessary to prove the mental deficiency beyond a reasonable doubt. All that is necessary is to prove it by the fair overweight of the evidence, that is to say, balancing all the evidence in favor of the claim of mental deficiency and all the evidence against it, the former must outweigh the latter to an appreciable extent in its convincing power.

As to the kind of evidence that will be received in court, it is, of course, to be understood that the actual mental subnormality must be established by people who are experts. Naturally these may be doctors, psychologists, psychiatrists, psychiatric social workers, and probably ordinary social workers. It is assumed that these have had so much experience with this type of case that they would recognize by the conduct of the patient the symptoms of mental deficiency. Doctors, psychologists, and psychiatrists are, of course, in a class by themselves. The

I.Q. or mental age of the patient is always an important although not a decisive factor. That can only be proved in most cases by the testimony of the person who conducts the examination. The social worker, on the other hand, presumably has had enough experience with the mentally deficient to know how they act or how they respond to certain environmental influences and are able to express an opinion as to the mental condition of the patient based upon this wide and varied experience. The doctor, the psychologist, the psychiatrist, and the social workers would, no doubt, qualify ordinarily as expert witnesses.

In addition to that, non-expert witnesses such as relatives, friends, associates, neighbors, teachers, nurses, employers, police, and pastors would be able to testify to facts that they observed either favorable or unfavorable to the patient from which they and the judge could draw inferences as to whether or not the patient is one who is subnormal mentally, requires supervision, control, or care for his own welfare or the public welfare.

Both experts and non-experts are qualified to testify as to the conduct of the patient, his declarations and mode of conversation, his appearance, the family history and family life, school records, work habits, use of tobacco, liquor, and drugs if out of the ordinary, ability to get along with people, or any other observed fact.

What is not permitted in court in such inquiries is rumors, gossip, hearsay, organizational records purporting to contain family histories, unsupported inferences, and unproved generalities or opinions. Likewise, the mental deficiency of the patient cannot be proved by specific acts of misconduct by siblings unless connected directly with the alleged defective. It is probably safe to say that mental deficiency cannot even be shown by isolated acts of misconduct by the patient unless they are shown to be a part of a pattern of misconduct.

Perhaps the most important feature for the social worker to remember in a case of this type is the personality of the judge. The judge presumably understands that proceedings to inquire into the mental deficiency of an alleged defective are not adversary in the ordinary sense, that is to say, the judge is really conducting an investigation. The County Attorney in participating in such an investigation presumably is not trying to "convict" the patient. His function is to help the judge to get the facts. His primary interest is perhaps the welfare of the public, but certainly he is also interested in the welfare of the patient. Ordinarily, the attorney employed or appointed to represent the patient is more interested in attempting to clear the patient than in simply an unbiased search for the truth, but that is not altogether to be deplored inasmuch as in the long run probably less injustice is done by a vigorous defense of the alleged defective than by a lukewarm or indifferent defense.

The judge in passing upon the issues has in mind first of all, no doubt, the welfare of society, the safety of its members from harm through the conduct of the mentally defective and also, although of considerably less importance, the possible increase of the tax burden if the patient is found to be mentally defective and subject to confinement when, perhaps, such a conclusion is not satisfactorily established. The judge also, undoubtedly, will have in mind the rights and the feelings of the parents. The judge is reluctant to hang a label of mental deficiency upon any person, young or old, is reluctant to break up a family by removing one member from it, and is reluctant to interfere with the freedom of movement and of conduct of any individual in his community without adequate proof.

Perhaps in this connection it may not be out of place to say that a judge is not likely to be overly much impressed with the importance of social workers, the

findings of psychologists, or even the opinions of psychiatrists. A judge is accustomed to having witnesses make positive and irreconcilable statements on opposite sides of many controversies, and he learns to maintain his judicial equilibrium regardless of the expertness or social position or prestige of the witnesses. The judge refuses to be a rubber stamp to marking a person down as a mental deficient merely because the local welfare board or some local welfare agency is convinced that this should be done. The judge is not a trained social worker, a psychologist, or a psychiatrist, but he is trained in the principles of individual liberty and in the freedom of the individual from public restraint in the absence of any misconduct by the person so brought into court or in the absence of evidence sufficient in law to permit a finding that he is mentally deficient with its three necessary characteristics as stated above. Even the testimony of several reputable psychiatrists might not be sufficient to persuade the judge.

In the case of an application for restoration by one adjudged a mental defective, the burden of proof is upon the applicant to establish that he is at the time of the hearing entitled to be released from guardianship. This raises the rather interesting question whether mental subnormality is curable. But even if it should be held that mental subnormality is not remediable or amenable to improvement, it might still be shown that the defective while under control has been so trained that he is now able to take care of himself without risk to his own welfare or to the public welfare if given his freedom. Should the defective make a showing of that kind by the fair overweight of the evidence, then it would become the duty of the judge to restore him.

It is very likely that there may be times when the social worker or the local agency will feel that the judge has erred in refusing to find a patient to be a mental defective. On behalf of the judge who may thus disappoint the petitioner or the proponent of the case, it should be said that there undoubtedly are cases in which the social worker or the local agency may be mistaken. Consequently, a judge is entitled to the same privilege of now and then making a mistake. In any affair of life or in any appraisal of an institution it is the overall picture that must be examined rather than specific instances of success or failure. A few instances of brilliant success are no more a proper basis for criterion than a few instances of signal failure. On the whole, it is believed that the judge will exercise sound judgment in these cases just as he does in other cases, trying to keep the scales evenly balanced between the protection of the public and of the defective and the liberty of movement and good name of the defective and his family.

WHAT THE COMMUNITY OWES TO THE MENTALLY DEFICIENT AS SEEN BY HIS FAMILY

R. T. Lindh*

The Association of Friends of the Mentally Retarded was organized in 1946 by parents and relatives of children receiving care at Hammer School. It began as a parent-teacher organization of that school but has been expanded into a statewide organization.

Parents or guardians of the mentally deficient or any person interested in a specific case of this type may be an active member. Public spirited people who are interested in the general welfare of mentally deficient persons may become associate members. The dues are \$1 per annum. In addition to the membership, there will be a group of specialists in mental deficiency chosen as an advisory board.

The Association has printed a leaflet giving some facts, and I am quoting from it as to its aims and purposes.

1. Education of the public and legislators to understand and sympathize with the mentally retarded individual and his problems.
2. Improvement of state institutions. Proper beds and accommodations. Ample grounds for activities. Recreational facilities. Proper food and the adequate and proper facilities for the preparation and serving of foods and beverages. Adequate sanitation--keep patients clean. Adequate wages. Special training courses for attendants and teachers.
3. Research with reference to the elimination of the causes of mental deficiency. Research dealing with the treatment of individual cases involving possible surgery, training, or other special treatment.
4. Action to initiate work on the above points through our representatives with the proper state agency or through the subscription of private funds where the work is outside the realm of public support.
5. Education of parents of retarded children and assistance in helping them to rationalize their emotional disturbances in these cases.
6. Proper consideration of the retarded child in the public school program.
7. The encouragement of small schools for the mentally retarded through the elimination of impractical labor and fiscal regulations which tend to handicap the school manager and force his tuition fees beyond reason.
8. Furnishing certain luxuries, treats, presents and in some cases clothing to institutionalized people, that the State, by statute, cannot provide.

This same leaflet indicates what members can do, as follows:

1. Tell their neighbors about the problems of mental retardedness.
2. Write or see state or national representatives regarding passage of legislation helping the retarded.
3. Make a place for rehabilitated persons in the community.

4. Be a big brother or sister to some parentless patient of a state institution and send him cards or gifts throughout the year.

5. Send toys, radios, and musical instruments, new or old, to the institutions on Christmas.

6. Use their influence to arrange programs for institutionalized people.

Persons interested in learning more about the Association may write to me at 2906 - 29th Avenue South, Minneapolis 6, Minnesota.

* Summarized by Mildred Thomson.

WHAT THE COMMUNITY OWES TO THE MENTALLY DEFICIENT AS SEEN BY THE SCHOOL

Clara Thorpe

To answer the question "What does the School owe to the Mentally Deficient Child" is in this day a real challenge to any individual or groups of individuals concerned with the important business of planning a worthwhile education for girls and boys. There appears to be so much confused thinking and there are so few who seem to know the right answers. I am reminded of the little boy who came home one day and said - "My teacher doesn't know much. She hasn't even seen a house. I drew one today and she didn't know what it was". At present we do not know just how to proceed because of the differences of opinion which exist. On the one hand there are leading educators who propose that erecting large buildings and increasing the attendance unit to at least 1200 pupils will solve all of our educational problems. On the other hand there are those who insist that we must break down our attendance units into much smaller groups so that provision can be made for meeting the needs of each individual child. It appears, without question, that if each child is to receive the equal educational opportunities which are being advocated, his individual needs must be recognized.

Let us see what the Charter of Education For Rural Children provides as a result of the first White House Conference on Rural Education. While the county superintendent's work is largely with the one-room rural school, when I use the word "rural" I am thinking of the educational opportunities which should be provided for every child in our state which is, of course, mostly agricultural and made up of rural communities.

1. Every rural child has the right to a satisfactory, modern elementary education.
2. Every rural child has the right to a satisfactory, modern secondary education.
3. Every rural child has the right to an educational program that bridges the gap between home and school, and between school and adult life.
4. Every rural child has the right through his school to health services, educational and vocational guidance, library facilities, recreational activities, and, where needed, school lunches and pupil transportation facilities at public expense.
5. Every rural child has the right to teachers, supervisors, and administrators who know rural life and who are educated to deal effectively with the problems peculiar to rural schools.
6. Every rural child has the right to educational service and guidance during the entire year and full-time attendance in a school that is open for not less than nine months in each year for at least twelve years.
7. Every rural child has the right to attend school in a satisfactory, modern building.
8. Every rural child has the right through the school to participate in community life and culture.

9. Every rural child has the right to a local school system sufficiently strong to provide all the services required for a modern education.
10. Every rural child has the right to have the tax resources of his community, state, and nation used to guarantee him an American standard of educational opportunity.

The charter's closing statements read in this manner.

These are the rights of the rural child because they are the rights of every child regardless of race, or color, or situation, wherever he may live under the flag of the United States of America.

These are glorious aims and should materialize some "happy" day. However, there are many of us who say that we cannot afford to wait until that day comes. The time for action is now and we owe serious consideration to the mentally retarded child. In any school the emphasis should be upon the needs of the whole child. The child who is mentally "fast" needs as much attention as the retarded one.

Immediately the educational plans should include opportunity to study the phases of child growth. The following questions should be asked and every attempt should be made to answer them:

1. How can the schools apply the principles of mental hygiene?
2. What school policies and procedures need to be changed?
3. What type of personnel is needed?
4. What training in mental hygiene should be provided for every teacher?

The four general topics which need consideration are:

1. The emotional and social background of each child - the teacher should know homes and parents.
2. The adaptation of school programs to pupils' mental abilities. There should be a carefully planned testing program, the results of which would indicate the readiness level of each pupil for learning.
3. Identification and guidance of pupils with emotional problems.
(New Curriculum philosophy)
4. Instruction relating to mental hygiene especially for teachers, but also for parents.

The time was when parents, after they had taught their children to say "yes, ma'am," "thank you" and "if you please" and not to eat their peas with a knife, then asked the school to make the child a man. Oh, they also expected him to learn to read, write and figure. Now we know that we must discover and channel and gear our human resources to meet a fast-moving, hard, realistic life. Somehow, somewhere there must be a definite promise of security for the pupils as well as the teacher. All this will cost money, take time and require serious consideration and much effort.

What is our starting point?

1. See that class-room loads for teachers are smaller.
2. Make courses in mental hygiene a "must" in teacher training and preparation.
3. Provide trained supervisors for all types of schools.
4. Require workshops to be set up which will show how the school program can be adapted to the child's mental abilities. There should be opportunities for "on the job" training for every teacher. Workshops should be set up in which careful definition and application of the principles underlying the new curriculum philosophy could be offered to the teacher of any group of elementary pupils.
5. Every county should have at least one public health nurse.
6. A trained child welfare worker for every county.

The American ideal of teamwork must enter the picture here. No one agency in a community, such as the school, can take responsibility for carrying out this important and necessary change in educational policy. All agencies must combine efforts, resources and vision so that every child, even the mentally retarded, may receive just consideration.

What are some counties doing? It is with no intention to boast that I point out what I have been attempting to do in Yellow Medicine County. My first visit to a rural school at the beginning of each school year is not for inspection purposes but to try to help the teacher identify the pupil who has emotional problems. During a conference with the teacher, it is urged that much patience be used in handling the pupil who apparently is not making proper emotional adjustment. If mental retardation is suggested, the teacher is asked to withhold judgment until as much information of family background as possible can be obtained. Visits to the home and conferences with parents are encouraged. If special aptitudes are noted in the slow pupil, these are to be encouraged as well as sensible participation in extra activities. Every attempt is made to enlist the cooperation of other agencies in an attempt to solve special problems. In our county splendid cooperation has been received from the local welfare agency, judge of probate, sheriff, county attorney and others who have been contacted. Teachers and parents are encouraged to confer with the family physician as much as possible. Much help has been received in obtaining aid from this source to secure further study of some especially difficult cases.

As a out-growth of the health conferences which were held in Minnesota during the past fall months, several meetings pertaining to "Mental Health and the School Child" have been held in the county. All teachers from rural and town schools met in Clarkfield on October 12, 1948, when very stimulating panel discussions were held on Mental Hygiene, Physical Education and Nutrition. The rural teachers have met in small groups and discussed problems pertaining to individual needs and pupil participation in certain plans. Some rural P.T.A. groups have held interesting meetings on Mental Hygiene. It is planned to include a session on this vital topic in the program for the annual schoolboard meeting in the county. Nothing seems more important just now than to try to educate the adults to see their responsibility to the mentally retarded child.

What does the school owe the mentally retarded child? Exactly what it owes to a normal child. The following bit of poetry tells the story, it seems to me--

A smear of ink on a pink, round thumb
A little girl is doing a sum.
Thin little arm moving busily -
"Put down seven and carry three".
Brown legs curled round the rung of a chair
And lamp-light on that soft brown hair.
Far away look in those gray-blue eyes,
The child asks - "Where does the river
Tiber rise?"
And you ask - "Oh little brown head with
your eyes gray-blue,
What will your wisdom lead you to?"

WHAT THE COMMUNITY OWES TO THE MENTALLY DEFICIENT AS SEEN BY THE CHURCH

Harold Belgum

The average person regards the mentally deficient individual with a mixture of fascination, superstition and pity. Neither does he understand typical causes of such condition, nor does he appreciate the problems of the individual and his family.

The clergy, church leaders and members, as well as the church considered as an institution, have an obligation and an opportunity to help the mentally deficient and their families.

I. The church owes something to those who remain in the parish:

- a. The matter of interpretation to the family and relatives of the mentally deficient in order to give them a better understanding, help them adjust to the realities and provide them with information on treatment and educational resources available to the mentally deficient.
- b. The matter of interpreting to certain key people in the congregation these same facts, particularly the facts regarding understanding and adjustment so that the congregation, which can be called a community within a community, can better incorporate the individual concerned and accept him with his limitations as having a place in the whole structure.
- c. The matter of preparing the family and key persons in the congregation for the departure of a mentally deficient child or adult who is to be admitted to an institution, the maintaining of a kind of friendly contact during institutionalization, looking forward to reacceptance of the individual into the family and the congregation if the period of institutionalization is terminated.

II. The Church owes something to its members who are in institutions for the mentally deficient:

Here we may need to think of the church as an institution rather than of individual persons or congregations relating directly to the institutionalized person. To illustrate, from the area of the Lutheran church a group of national Lutheran church bodies work through Lutheran Welfare Society to give social work services and spiritual services to unwed mothers, to dependent and neglected children, to persons in hospitals and sanatoria far away from their own family and pastor. The services in the latter area are carried on through chaplains.

There is a growing recognition of the need of chaplains from various faith groups to serve the spiritual needs of persons in all types of institutions. An indication of this growing concern for the spiritual needs and hungers of institutionalized persons is the recently appointed Governor's Advisory Committee on State Chaplaincy Service. Representatives of the various faith groups are even now working out recommendations for a strengthened and extended Chaplaincy program in the state's institutions.

The various churches have shown their concern by increasing recognition

of the importance of special training for chaplains giving these specialized services. Clinical training for such chaplains under competent supervision is being used to strengthen the techniques of pastoral work to supplement the training received in regular theological training. It is felt by many church leaders that in this way the spiritual therapies of the church can in turn supplement and strengthen the many recently developed scientific therapies from which the clients benefit in institutions.

There is a rising tide of concern among the clergymen as well as laymen and women of the church for the emotionally disturbed or mentally deficient individual. Many have shown it by their interest in mental health education. This interest argues that the church, whether considered as a congregation or as an institution, or as regards any of its personnel, can give great aid and comfort to the mentally deficient child or adult, and to his family. It also argues that persons in responsible positions working with the mentally deficient would do well now to bring church people into their counsels and enlist their cooperation in all aspects of their programs.

WHAT THE COMMUNITY OWES TO THE MENTALLY DEFICIENT AS SEEN BY THE PHYSICIAN

Reynold A. Jensen

From the point of view of the physician or psychiatrist, the community owes the mentally deficient child and his family at least two things. First, early and accurate diagnosis. In this process all possible conditions suggesting mental retardation should be considered and ruled out. Diagnosis should be made at the earliest possible moment and every tendency to procrastinate avoided. Second, a willingness on our part to accept the parents' problem seriously and to consider it thoroughly with them should be clearly indicated. With regard to the latter several basic principles, if kept in mind, will be helpful:

1. The core of the problem is resolution of the parents' strong emotional attachment to the child.
2. The total situation requires ample time for thorough appraisal.
3. All words heavily charged with emotion such as Mongolian, idiot, imbecile, moron, feeble-minded, etc. must be avoided and less threatening words substituted.
4. A strict attitude of objectivity must be always maintained. This objectivity must be tempered with patience, kindness, and understanding.
5. At no time should decisions for the family and their children be made. This is the parents' responsibility. Our responsibility is fulfilled when all possible plans for the youngster in question are completely considered*

The problem of the mentally retarded individual is a problem in which all must be interested,---physician, psychiatrist, social worker, school teacher, public health nurse. Every effort must be made to define for one another the area in which each is to function. With this understanding it should be our goal to develop more favorable attitudes on the part of the general public regarding this important problem.

We can, through our joint efforts, encourage more adequate provision for the educable. This necessitates the establishment of special classes in strategic areas throughout the state where educational opportunities can be offered commensurate with ability. All of us should encourage strengthening the program at the Owatonna State School.

For the totally inadequate individual requiring custodial care, the development of increased facilities, more adequate staffing, and better programming should be encouraged. Should a family elect to maintain their youngster in their own home, help, guidance, and direction of the parents as required should be available.

Finally, we should intensify our efforts toward concerted action. The problem is of such magnitude it cannot be solved satisfactorily otherwise.

*Note: In discussion Dr. Jensen brought out the fact that if the mentally deficient child becomes a social problem the community may need to act for his protection and that of other children even though the parents may not wish it.

WHAT THE COMMUNITY OWES TO THE MENTALLY DEFICIENT AS SEEN BY THE SOCIAL WORKER

Frances Coakley

In the supervision of the mentally deficient the social worker has the responsibility of utilizing all of the resources within a community. The community's responsibility for the mentally deficient has been shown in a very definite way through the commitment procedure whereby a mentally deficient individual may be committed to the guardianship of the Director of Public Institutions, who in turn delegates his responsibility to the local county welfare boards. The fact that such a commitment law was passed indicates that there was community support and a feeling of public responsibility for the mentally deficient. Since the commitment is a permanent one, supervision is a continuing responsibility.

Since the social workers are working directly with the mentally deficient, it is well that they understand the people with whom they are working. The mentally deficient are like us in many respects, having emotions and sensitivities in many respects the same as you and I. Dr. Robert M. MacIver of Columbia University in his Preface to the "Sub-normal Adolescent Girl" writes, "The sub-normal girl is not a freak of nature. She is not a peculiar variety of human being. She is not a specific type with an abnormal behavior tendency. She has the same needs and desires as others. She is as endlessly variable in her make up as any other category of person. She should be treated as an ordinary human being who requires special care, protection, and understanding, one whose very aberrations are due to the fact that she is as healthily human as anyone else but more at the mercy of circumstances that the normally intelligent find easier to overcome. The way to treat her is not the way of superstition. It is not the way of pity, or of blame, or of pride, or of shame. It is not the way of those who preach at her, or of those who condemn her, or of those who abuse her."

The philosophy that one formulates in working with the mentally deficient is primary in determining how successful and effective one will be. The attitude of friendship has seemed to be one that has been most successful. It means that the worker develops certain personal characteristics herself, such as kindness, patience, fairness, and wisdom. Along with this we must have optimism, at least to such an extent that we are able to determine an individual's assets and help that person build upon them.

What are the essentials in supervision?

First, one must have the ability to recognize mental deficiency. Diagnosis is dependent upon the use of many other individuals within the community such as the doctor, the psychologist, the school, the teacher, the minister, the employer, and any individual who is able to give a better understanding of the mentally deficient person's personality. In diagnosis we must be careful to determine that we have carefully explored all areas which might be providing barriers to the true expression of his mentality.

After recognition, there must be understanding. Here Dr. MacIver's statement regarding the mentally deficient is important in that we treat them not with pity, or blame, or pride, or shame, but as human beings, differing from us mainly in the level of their mental development. Understanding means knowledge of mental levels, knowledge of how the development of the mentally deficient varies from the normal, and recognition of both the limitations and abilities to be found within the various individuals of certain mental levels. It means a recognition of positive characteristics within an individual, such as recognition of a mentally deficient person's initiative and his ability to develop it,

Thirdly, one must accept the mentally deficient person, recognizing his limitations and helping him develop his abilities to the highest possible level.

Fourth, encouragement or inspiration is a large factor in successful supervision. Much of the case work will be through the use of the "supportive techniques." Much of the success will depend upon proper encouragement for a job well done.

Fifth, great authority is given to the social worker working with the mentally deficient. That authority should be used very carefully and wisely not only for the protection of the community, but also for the protection of the ward. Occasions may arise when it is very necessary to verify charges or accusations made against a ward to determine that they are true and correct and that they are not made on the basis of rumor or circumstantial evidence. In actions to protect the community, it is well for the worker also to keep in mind the needs of the mentally deficient ward. Here, the worker will want to be sure that she is being fair and just.

Sixth, a very large responsibility rests upon the social worker for interpretation of the mentally deficient to the whole community, most specifically in individual situations to the family, to relatives, to the employer, to the school, to the church, to the doctors, and public health nurses.

The areas of supervision run the whole gamut of human experiences. Dr. E.J. Humphreys in an editorial in the American Journal of Mental Deficiency in January, 1943, expressed the philosophy that the mentally deficient may be an asset within the community. He wrote as follows: "Whether for war or for peace, all units of society should be integrated toward a common working efficiency in national or international life. This means that each individual, the basic unit of society, must be advantageously related to the total social structure. Not one should be neglected - either in a state school, in a factory, in a university, or elsewhere. Each human being has an unalterable fundamental value in the total biocultural economy of man -- no matter what the intelligent quotient or the property quotient may be. We who assume responsibilities in society should search for individuals possessing capacities for leadership and indeed for the followership as the prospector seeks oil. He discovers oil in vast caverns. He also finds oil in shales. There are different ways of obtaining oil from caverns and from shales--but the final product is oil. We are now seeking all possible sources of manpower for the war effort, and we shall also have to do so in the effort to reconstruct society. We are draining our vast caverns of manpower directly into the Armed Forces or into War Industry, but we have been grossly neglecting certain rich shales of labor which contain huge resources in the terms of potential manpower for restricted but important service in war or in peace. Stretching our idiom - we are neglecting important labor groups - shale labor, perhaps, but nevertheless--invaluable human labor."

With careful, sympathetic supervision a large share of our mentally deficient can adjust satisfactorily within a community. Areas in which the community, through the social worker, may assist are in education and vocational placements along with good supervision of savings and budgeting, recreational plans, health planning, encouragement to participate in religious activities, and assistance in personal living and family situations.

Where there is a low grade mentally deficient child within a home the social worker has the real responsibility of helping to plan for future care of that child and also to help those parents work out some of their emotional conflicts. As Dr. Heynold Jensen said, the responsibility for making decisions regarding plans for this type of child rests with the parents although the social worker may give her opinion if asked to do so.

Institutionalization is a definite part of supervision and a community responsibility for those individuals who are unable to adjust satisfactorily within the community. For those who are removed from the community institutionalization has a definite therapeutic value and is part of longtime planning for that individual. While the ward is in the institution it is still the responsibility of the local community to cooperate with the institution and to prepare a suitable plan for return to the community when that is recommended.

The challenge that I would like to give to the social workers is that of better education and interpretation to their communities. Such interpretation is given through every contact that the social worker has with the mentally deficient and with his community. A challenge is given for every social worker to do good mental hygiene work and through utilizing the resources within the community to encourage such conditions that the mentally deficient individual within his community may develop to the highest level of his mentality.

PUBLIC SERVICES OF THE DIGHT INSTITUTE

Sheldon C. Reed

The Dight Institute for Human Genetics is a part of the University of Minnesota but is supported by endowment and not from public funds. The services it can render are considerable and they are free to anyone, anywhere. The only limiting factor to its services so far has been its small endowment. The endowment, though small, insures continuity of the program, and Minnesota is one of the very few states fortunate enough to have such an Institute.

The founding of the Institute was the result of the vision and public spirit of Dr. Charles F. Dight, a physician of Minneapolis who died in 1938, leaving his estate for this purpose. Dr. Dight always had a small income but his expenses were also modest. He built himself a house in a tree, thus limiting possible expansion, and neglected paying income taxes. It has been said that he lived in a tree as he feared grass fires. While possessed of a number of personal idiosyncracies, Dr. Dight had a clear mind and realized that the new science of human genetics gave great promise for the happiness of mankind and that to succeed, it must be supported. With the above in mind he stipulated that the Institute should have three main functions.

1. The Institute, through its director, should give instruction in human genetics not only to students in the University but to groups anywhere upon request. Talks have been given at the annual meeting of the Minnesota Council of Social Welfare Workers, at the Adoption Council, at the Council of the Social Agencies for the Blind, and to many church and civic groups.

2. The Institute is to carry on research projects in human heredity. The largest project at present is concerned with the heredity of breast cancer and is supported by grants from the American Cancer Society and the U. S. Department of Public Health.

A collection of over 40,000 pedigrees of the inheritance of different traits provides background for requests as to the inheritance of particular ones.

A large collection of records on inheritance of mental deficiencies in past patients at Faribault will provide the basis for a new research project on this important problem.

3. The service which is available and most useful to the Welfare Worker is that of Counseling in Human Genetics. Perhaps this can be best described on a "case" basis.

Up to the present the largest number of requests for information on heredity have come from the Child Placement Agencies. A few of their problems are listed below.

- A. Request. "John's mother is 'white' and her ancestors we are sure were all white. John's adjudicated father was the son of a colored woman and a white man. John's father 'passed' as a white person and his colored ancestry has not been suspected by his white companions. Jackie, himself, is very 'white'. His hair is straight and dark, his eyes large and brown with very long lashes. His complexion is fair, and he has a generous supply of freckles. The adoptive mother, while she is convinced that she wants Jackie for her own, wonders about the possibility of his children having prominent Negroid characteristics. She would consider coal black grandchildren to be something of an embarrassment to her. Your opinion will

be forwarded to the adoptive parents. May we hear from you soon?"

Reply. "I can state positively that any children born to John and a truly 'white' woman will be 'white'. We know that there will be no reversion to characteristics any more negroid than those which John may possess. The geneticists know that in heredity most negroid characteristics are dominant to the comparable characteristics of white people and such dominant characteristics cannot be concealed. Consequently no negroid characteristics could show up in John's descendants which he does not show himself."

B. Request. "Enclosed is our Child Referral Summary for Helen M. The agency to which she was referred did not feel that they could accept her for placement as her grandmother has Huntington's Chorea and is becoming progressively worse. We do not know just how to handle this. In your opinion is Helen suitable for adoption?"

Reply. "It is fortunate that you have a definite diagnosis in this situation, as otherwise it would be impossible for me to offer an opinion. Huntington's Chorea is one of the few mental disturbances in which the heredity picture is exact and clear cut. It is inherited as a dominant character and there is one chance in four that Helen will eventually develop the disease. Should Helen's mother, who is now eighteen, develop the disease the chances that Helen will do so too, rise to one chance in two. If Helen's mother never does develop the disease then Helen never will either. If Helen does develop the disease she is not likely to do so until after the age of say 25, at any rate not until she has left the roof of her foster parents. I would suggest that she is a fair risk and that she be placed with parents who are willing to take this kind of a chance."

C. Request. "We are interested in the possibilities of hereditary transmission of mental illness in the family background of two state wards. We would like to place them in an adoptive home if the dangers of mental illness are not unusually great. The mother of the two little girls was admitted to a state hospital at the age of seventeen. The diagnosis of her mental illness was manic depressive psychosis, manic type. She was paroled in a few months and discharged as recovered after a little more than a year. A paternal uncle of the mother died in the same state mental hospital and a maternal uncle is at present a patient in a different mental hospital. The mother's father is described as an extremely nervous person. Paternity of the two daughters, who were born since the release of their mother from the state hospital, has not been established."

Reply. "Manic depressive psychosis seems to be inherited as a dominant character in the large mass of pedigree material available. This means that we expect half of the children of a manic depressive to develop this psychosis at some time during their lives. While we expect half to develop the disease in theory, fortunately only one third of the offspring actually appear at medical centers for treatment. Using this new figure of one third, the chances that neither child will ever develop the disease are 45 in 100; the chances that one, but not the other, will develop the psychosis are also 45 in 100; the chances that both will develop the disease are only 10 out of 100. The chances are 55 out of 100 that one or both will develop the disease at some time. To what extent does the state wish to protect the foster parents from possible future discomfort? This question is not my problem, but it is clear that the future foster parents must be warned of this misfortune which might develop. It places them in an awkward position because if they are still eager to adopt the children it would seem that they are careless about their own future and might likewise make little provision for the future of the children."

The second largest group of requests for information concerning problems of human heredity comes from physicians. A few of these follows:

D. Request. An obstetrician has delivered an albino child to a prominent family. The young couple is much perturbed about the situation, and wonder what the chances are that the next child might be an albino.

Reply. About one child in every 20,000 born is an albino. The chance that this unhappy couple will produce an albino at the next "try" is exactly one in four, statistically speaking. This character is well known to be inherited as a recessive, it follows Mendel's law, both parents obviously carry the gene for albinism concealed by a normal gene on the other member of the chromosome pair. One person out of every 150 in the general population carries the gene for albinism, which is rather surprising, but it is not often that two individuals, both of whom carry the gene, happen to marry.

E. Request. A young physician has just become the father of his first child. The child has an extremely ugly case of bilateral hare-lip and cleft-palate. What are the chances that a future child might also be born with this abnormality?

Reply. From data in our files at the Dight Institute about five percent of the families which produce a child with hare-lip and cleft palate later on produce a second child with the same difficulty. As one chance in twenty of having a second child with hare-lip and cleft palate seems to be rather small, I would certainly plan on another child.

Many requests for counseling come from the student body.

F. Student A has had three children, two of whom are Mongols and are at Faribault. The problem is of such emotional weight with this student that he was unable to bring himself to ask the questions which I am sure he had planned to ask.

Student B had just become the father of his first child, a Mongol. The student at first wondered what was wrong with his wife, then he wondered if certain sex practices could have been responsible. I pointed out to him that on his right hand he had the "Simian Crease" a peculiarity of Mongols and some of their blood relatives. When it became clear to him that some kind of hereditary background of the usual sort was involved, his adjustment to the problem became matter-of-fact and reproach disappeared.

Student C is engaged to one of identical twins both of whom has psoriasis. Is it hereditary? Yes, and half of their children will have it. Is it important? Not particularly.

Finally, there are genetic inquiries from the general public. The most frequent questions from the public concerns inbreeding or consanguinity.

G. Request. "What may be said for or against marriage of an uncle and his niece?"

Reply. It is not legally possible for an uncle and niece to be married in Minnesota. The law states that marriages closer than that of second cousins are forbidden. Both church and State frown on the marriage of relatives. The science of genetics provides the reasons for this attitude. It has been found that practically every person "carries" concealed characters, which do not show in himself as they are covered up by the normal character which is therefore called dominant. The concealed

characters are called recessives as they express themselves only when present in the individual in a double dose. Some of the recessive characters are deleterious and cause freaks or abnormalities when they are present in the double dose.

If a couple married and are not related the chances are very small that both will carry the same deleterious recessive and thus risk a defective child. However, a related couple has ancestors in common and therefore greater chances of both getting the same deleterious recessive genes from a common ancestor. Relatives produce more abnormal children than non-relatives.

The above cases illustrate to a small degree the kinds of counseling which can be done for the people of this state. While to those who have none of the problems listed, these cases may seem superficial, to the families in which the situations exist, the solutions and knowledge about the conditions are of vital importance. Consequently I shall not spare myself in trying to give counsel to all who have questions which depend for their answers upon the science of human genetics.

MINNESOTA SCHOOL FOR FEEBLE-MINDED

E. J. Engberg

The present population of this institution is approximately 2850. The patients range from infants born here to a number who are now quite old and who have been here since they were little children. The oldest patient is 90. Occasionally there are female wards who are admitted for confinement care. The infants born to them are cared for in a separate nursery in the hospital until they are three months of age, and then plans are made for them. There are, however, infants who have been placed under guardianship at only a few months, or even a few weeks of age. These are severely handicapped and consist mainly of the mongoloid, hydrocephalic, and certain spastic children.

A large percentage of the patients are those requiring physical care. Aside from the crippled cases, there are others who are so low mentally that they are not capable of caring even for their personal needs.

There are, however, many other groups who can profit by a training program. A School Department, consisting of twelve teachers, has nursery school, kindergarten, and ungraded rooms in session, as well as handicraft and sewing classes for those who have the same mentality as the group which were transferred to Owatonna. Besides older boys and girls, the latter includes brighter children who, because of an added physical or emotional handicap, do not fit into Owatonna, and who are given individual instruction on a part-time basis, to the extent that we have facilities. Those who attend the nursery school classes and kindergartens are from the imbecile and low moron groups, many of them mongolian, who can receive recreational and social training which makes their adjustment here more enjoyable and which helps them to fit into the home group at vacation time. The School Department is in charge of all recreational and religious activities, as well as the actual teaching.

Most of the patients who are of moron mentality are over eighteen years old, with the exceptions as previously indicated, and also some who have been delinquent. Training is provided by means of a work detail, supplemented by attendants, at classes which consist of sewing, brush making, weaving and netting. Besides the classes in the School Department proper, four teachers conduct classwork in buildings wherever there are groups capable of responding; The work detail comprises cleaning, janitor service, dining room service, assisting in shops and helping to care for patients in the infirmaries and hospital. There is a farm, a garden colony, and a dairy, where groups of men live who do the work, under careful direction, that is necessary for maintaining these agricultural pursuits. This is excellent preparation for placement on farms outside at a later date. There is also a power machine shop, where many women learn to sew while making some of the clothing needed. A large laundry, which operates for both patients and employees, furnishes work for many adults according to their ability.

There is also a librarian, who not only helps patients select books in the library and tells stories to the children, but takes books to the buildings where there are patients who cannot come to the library.

All food is cooked in a central kitchen, except in more remote cottages, and then sent in hot containers through tunnels to the buildings where it is kept in steam tables while being served. Each building has its own dining room.

In an institution of this size the question of health is a serious one. There

were delays in filling the new buildings due to infections. At one time an employee was found to have clinical diphtheria, and tests where she worked showed some thirty children in that building were also positive, and until they were again negative no one else could enter. The importance of medical examinations and of the results being received here before entrance is thus apparent.

All patients on entrance go to the hospital. The time necessary to stay there is dependent somewhat on the adequacy of the previous examination. While in the hospital, the patient is studied and a case conference abstract is prepared, which is used in a case conference at which the patient is seen and is classified. Besides the hospital supervisor and physicians, the division supervisors, the social worker, and the psychologists, if testing at the institution, are present.

I have spoken very briefly, as even a short visit to a few buildings as examples of the institutional program will take much time. After going to the hospital, there will be visits to the dormitories caring for different groups, but mainly we will see a new infirmary in contrast to the old, the School Department, the laundry, and such other places as time permits. In particular, I hope to show you the preparation that patients are receiving here, so that you will be in a position to plan for their return to the community.

OWATONNA STATE SCHOOL

M. R. Vevlo

In discussing the operation of the State School, it seems we should limit the material presented to that phase of our work that is centered at the institution. I, will, therefore, not go into a discussion of commitments except to give a brief outline on the kind of referral report that we would like to have:

1. A complete social history, covering the whole family set-up. We should know about the father and mother, siblings, uncles and aunts, if they are a part of the family picture, and grandfathers and grandmothers, if they are a part of the picture. If mental tests have been given, these should be reported; otherwise an estimate of each individual's mental capacity should be made. Any health problem affecting the family group should be reported.
2. A complete history on the child in question. This should include his emotional responses and a rather detailed report on his adjustment in the family, the community and school. If possible, a definite statement should be made regarding religious affiliations. To say that he is Protestant is not sufficient. Also, it is important for us to know if the child has been baptized, and if so, date, place, Church and by whom; if he has been confirmed and if so, date, place, Church and by whom. A complete school report should be secured if the child has been in school. We would also like to have a written statement from his last teacher, which should be her interpretation of the type of school work he is able to perform.
3. All psychological data secured. This includes the date of the test, the mental age, the name of the test used, the name of the tester and the intelligence score. Copies of the tester's report should be included whenever possible.
4. Physical Examination. As thorough and complete a physical examination as can be secured should be reported. It may be difficult to get an accurate summary of the communicable diseases the child has had. If a doctor's report is available, it should be secured, otherwise the family's own report. Special attention should be paid to the examination of the eyes, ears, nose and throat. If possible, tonsillectomies and dental work should be completed before the child is brought to the school. All laboratory tests should be done and reports sent to us.

After the child is received at the State School, he is placed in our hospital for four or five days at which time we do a new nose and throat culture. This period of time gives us an opportunity to discover any health condition that should be known and which may not be reported and also gives us an opportunity to study the child and his history for the purpose of making placement in a cottage.

After placement in a cottage, the child is referred to the school department so that an achievement test can be given to him in order to determine the areas in which he is best able to do his academic work. It should be understood that the child may not and in many cases is not assigned to the level of work indicated by the school report.

The girls are assigned to cottages that are located together on the east side of our campus. These cottages face on State Avenue, which passes through our grounds. The boys are assigned to cottages that are located on the older part of the campus. These cottages are in a circle, leading off from the main administration building. Every precaution is taken so as to place the child with the houseparents that can best serve his needs.

In general the operation of the State School is on a co-educational basis. Boys and girls attend classes together and have other opportunities of getting acquainted and learn how to behave in the presence of the opposite sex. Necessary precautions and controls are set up. This has been a very useful educational feature of our work and has assisted in preparing the children for placement in the community.

The girls live in cottages with kitchens and dining rooms so that the training in cooking meals is available in their own cottage unit. The boys eat in a congregate dining room in the main service building. Menus are prepared a week in advance and the same menu is served both employees and children. There may, however, be some modifications, depending upon the supplies available. Children are not only permitted but encouraged to talk and to visit in the dining room. Training in proper behaviour, how to use the proper dishes and tableware, how to serve and be served are all taught in this area. The dining room has, therefore, become a very useful center for training children for eventual placement in the community.

All children attend school for half a day of academic work except for the two kindergarten classes which have a full day's work with the same teacher. Achievement tests are given to all children twice a year, in the fall and again in the spring to check on progress being made in different school subjects. All new children are also given achievement tests to determine what grade work they can do in each of the school subjects. They are then placed in rooms where children are doing work on the same grade level which they attained. All academic classes are coeducational and classrooms are kept as much like those in public schools as possible so that these children will have had school experiences similar to those of normal children when they get back into society.

With the exception of a few children who are being given specific vocational training, all children spend the other half day at school in industrial classes, music, gymnasium or library. We have physical education teachers for both boys and girls and they all have two periods a week at the gymnasium, one for swimming and the other for gyn. They also spend one period a week in the library where they are given the privilege of selecting books, which are checked out to them as in public libraries and taken to the cottages to read. Two periods a week are spent in regular music classes. The older boys and girls who have talent belong to the mixed chorus or glee clubs which rehearse every week.

The girls' industrial or craft program is quite complete. A cooking teacher gives them practical training in preparing foods and in planning meals. They learn how to lay out patterns, to cut, sew and fit clothes for themselves in their sewing classes. Knitting, embroidering, crocheting, and weaving - what we call the leisure-time crafts - are taught by two other teachers. The boys have one shop for woodworking and another in which they do some furniture repair as well as woodwork.

The fields in which boys are given a half day of specific vocational training are the bakery, dairy barn, farm, garden, and the laundry. Girls get training in the

laundry and in the kitchens at their cottages where the cottage cooks train them in preparing meals for fairly large groups. Other girls are given valuable training as waitresses in the employes' dining rooms, although that does not interfere with a full day at school.

The planned entertainment for the children consists of dances or parties four or five times during the school year, movies once a week, a series of entertainments through the University Artists Course, and programs offered by musical groups from town.

THE COLONY FOR EPILEPTICS

R. J. Gully

The Colony for Epileptics is one of the state institutions located at Cambridge Minnesota. It was built in 1925 as a dependent unit of the Minnesota School for Feeble-minded at Faribault, operated under its jurisdiction until 1927, at which time it became an independent institution.

It has grown from one self-maintaining building to an institution of its present size, which consists of an administration building, ten outlying cottages, auditorium, warehouse, farm buildings, and power plant; This institution was planned to care for high grade epileptic patients but during the past years a good many high grade epileptic are adjusting outside an institution and at the present time the majority of our population is feeble-minded as well as epileptic.

Individuals are received as voluntary admissions and court commitments. The lower age limit for admission is six years of age and there is no upper age limit. Some of the causes of epilepsy are the after-effects of acute infectious diseases, brain trauma, and arteriosclerotic changes. The various types of seizures are the petit-mal, grand-mal, status, series, and psychomotor seizures.

The treatment of the disease consists of care during the individual seizure, such as laying the patient in a position to avoid injury and giving them protection during the course of the seizure. Treatment of the disorder consists of occupational therapy, recreational supervision, education, and medication.

The medicines used at the institution are as follows: bromides which are used to some extent and chlorhydrates which are used rarely are two of the drugs still used in the treatment of epilepsy. In the beginning of the 20th Century phenobarbital was introduced and still is found beneficial in many cases. Since that time various drugs such as mebaral, sodium amytol, nembutal, and seconal have been used. More recently the use of dilantin, tridione, and mesantoin have been used. Our best results seem to be obtained from the use of phenobarbital and dilantin and a combination of the two.

During the past ten years the number of seizures have been reduced from 130,000 per year to about 68,000 per year. We attribute this largely to the increased use of dilantin at the institution.

We have approximately 250 children enrolled in the school department, about half of which are in the elementary classes and the remainder in the industrial arts classes. Most of the children with an I.Q. of 40 or over and under 18 years of age are enrolled in the elementary classes. They are doing work comparable to the work done in the elementary schools' primary grades up to and including 8th grade work. As a large percentage of the children are in the subnormal group, progress in school is much slower than in the ordinary public elementary school. The periods of concentration are limited to such an extent that they are kept in school for two periods during the day or about 1½ hours' work. As a result the progress is much slower than in the ordinary public elementary school, and many children 16, 17, and 18, years of age are still doing 3rd and 4th grade work while others are doing work comparable to 8th grade work. We have no definite grading system whereby letters or

grades are given individuals, since this tends to lead to a feeling of competition and inferiority complexes. However, a school record is kept on each pupil to give some idea of the type of work the individual is able to do. The industrial classes are made up of individuals of varying age, many in the middle years of life.

It is felt that all epileptic patients are not necessarily institutionalized since a high percentage is adjusting satisfactorily under normal environment. It is reasonable to assume that if the seizures can be controlled to the minimum and if the individual's I.Q. is sufficiently high that he can plan his own affairs and is not a social problem in employment, that he should be able to do non-hazardous, non-exhausting, and non-exciting work. There should perhaps be some consideration given for a sheltered program for epileptic individuals.

ANNEX FOR DEFECTIVE DELINQUENTS AT ST. CLOUD

Ralph Rosenberger*

What is the meaning of defective delinquent?

Many definitions of delinquency may be given. They fall into classes such as sociological, environmental and biological but the one definition we are most interested in is the legal definition. A delinquency is legally defined as any act or omission to act which is prohibited by law and entails a penalty.

But let us go a little further. A delinquent act in the United States, if committed in other parts of the world, might be the object of social approval. A crime in time of peace may constitute an heroic duty on the battlefield. Delinquency in its last analysis is dependant on circumstances, locality and point of view for its existence.

Webster defines defective as wanting in something; imperfect; applied either to natural or moral qualities.

Feeble minded means weak in intellectual power.

Thus a defective delinquent is someone who is weak in intellectual power and has committed an act or acts that society will not condone.

It usually follows that the reason for committing this delinquent act is because of the lack in intellectual power. While I agree in part with this statement, I do not believe that I can go all the way. Because this statement would imply that all people with a lack of intellectual power are potential trouble makers or delinquents and this I do not believe. I do believe that the mentally retarded have individual personalities just like normal people and most of them in the moron classification exhibit a fairly wide spread of personality characteristics. In most cases their delinquent behavior is due to faulty personality characteristics rather than lack of intellectual power. I will go along with the fact that lack of intellectual power is a contributing factor in faulty personality characteristics.

Recent studies which have utilized army draft groups as controls have found that the criminal group does not differ too significantly from the draft population so far as intelligence is concerned. In other words recent research leads to the conclusion that intelligence is not the most important factor in the etiology of criminal behavior.

But in defective delinquents there are certain characteristics of criminal behavior that merit mention because of the insight which these characteristics throw on the general psychodynamics of the feeble minded.

Most defective delinquents have an acute feeling of social inferiority, which in groups of persons with higher intelligence quotients breeds resentment and anti-social feelings. As a result of this inferiority the defective cannot find or fears to approach a willing partner of his own age and turns to juveniles or perversions as a means of sexual outlet or satisfaction.

Austin E. Grigg (psychologist - Virginia state department of correction) in a study comparing defective delinquents with a general prison population came to the conclusion that about 40 percent of the defective delinquents got into trouble

because of impulsive acts; that they react almost reflexadly to the heat of the moment with little regard for future consequences of their present action. The behavior does not exhibit foresight, does not project into the future. Only 19 percent of a general prison group fall into this classification.

Grigg also found that bizarre and illogical crimes may occur among the feeble-minded group as among the psychotic group. In his study 16 percent of the defective delinquents fall into this category while only 2 percent of a general criminal population fall into this category. Forty-four percent of the crimes do not deviate from those observed among delinquents of higher I.Q.

It has also been found that about 70 percent of defective delinquents have at one time or another been arrested for crimes against persons. It appears that the severely retarded adult is impulsive in his interpersonal relations and this factor gets many defectives into trouble. Only about 30 percent of a general prison group fall into this category.

The defective delinquent is also more prone to excessive drinking than those of higher I.Q. levels. This is particularly significant in those cases where environmental circumstances are vicious.

Thus we may conclude that:

1. A higher percentage of defective delinquents get into difficulty because of impulsive reactions to momentary stimuli.
2. The defective delinquent is more liable to be impulsive in interpersonal relations.
3. Bizarre crimes occur among certain defectives as well as psychotics.
4. Criminal acts of a majority of the defectives reflect inability to foresee the future consequences of present actions.
5. Defectives also follow the normal criminal pattern in that they adopt criminal careers in order to augment scanty earnings and as a response to vicious environmental factors.

6. Defective delinquent adults are more prone to excessive use of intoxicants. Generalizing, defective delinquents do not have the capacity for adequate foresight and thus often react to momentary situations without projecting into the future the overall results of the action. Because of faulty apperception of past events (as observed in memory tests - slow progress in learning, etc.) he carried into a present situation only a rudimentary projection of the past. Thus he is impulsive because it is his nature to react to the present with little ability to project his act either to the past or to the future.

It must be kept in mind that the above are behavior characteristics of the defective delinquent and show some difference between the defective delinquent and the delinquent. Even so one cannot necessarily conclude that lack of intellectual power was the sole cause of the delinquency.

Tredgold, long before child guidance or juvenile psychiatry had come into prominence, stated in his book MENTAL DEFICIENCY, "The child who is brought up in an atmosphere where self is supreme, in which lying, theft, and vice of every kind are rampant, can hardly be expected to acquire those ideals of social obligation and morality which are essential to correct conduct and the stability of a civilized society". His opinion is that anti-social conduct is largely the outcome of poor

environmental factors which tend to provide poor personal characteristics. Many other sociologists, criminologists, and specialists in the field of mental deficiency have made similar statements.

Now if we can go along with those authorities and feel that delinquency is due to faulty personality patterns due to faulty training somewhere along the line in developing personality characteristics and also believe that defective delinquents have personality patterns, then we can justify a training program for them FOR PERSONALITY IS SIMPLY THE PRODUCT OF REPEATED CHOICES. IT IS THE EFFECT OF MANY HABITS.

We feel in dealing with the defective delinquents as in dealing with our delinquents that faulty personality characteristics are the primary causes of their difficulties in making adjustments to society and that those personality characteristics can be altered through retraining and psychotherapy, both group and individual.

In handling delinquent groups, in fact, the whole basis of criminal reformation is based on developing proper social insight through retraining. Through this retraining we feel that faulty personality patterns can be changed to socially accepted patterns. The whole idea is that through retraining proper social insight will come by proper reasoning.

Because of the lack of intellectual power to start with in defective delinquents we do not expect to develop proper social insight by reasoning but by directed programs of correct habit formation. A class in Citizenship has been organized where, by discussion and repetition on what they should and should not do in specific situations, it is hoped certain good responses may become reflex. The instructor takes up these situations by relating actions to a study of a local community--its government, business, religious, educational, and recreational facilities brought down to the level of experience of each individual. Family relationships and responsibilities are considered in the same way as well as those with individuals with whom they come in contact.

In the same way they are taught better personal habits such as cleanliness, good posture, to look at a person when talking to him, to answer when spoken to, as well as those definitely associated with good conduct.

Although the men live in a dormitory separated from the cells of the Reformatory, they work in the various shops with the other men when they are ready to be assigned to individual jobs. First, however, until a man shows he has acquired good work habits and has the ability to learn a specific job, he is placed in a group doing some very simple job such as preparing vegetables.

The Reformatory has a very large enclosure within the walls which makes possible out-of-door activity. Various ball teams are organized with the same efforts made to develop leadership and sportsmanship as with the men of the Reformatory.

There have been a number of these men satisfactorily placed back in the community. The Protestant chaplain has added this job to his other responsibilities. When conduct and ability to work well indicate adjustment outside may be possible, the welfare boards are told of this and in some instances plans in the local community are made with the aid of the welfare board. More often, however, placements are made directly from the Annex without considering the county of settlement--indeed it is frequently best not to make a placement where the man was previously known. The welfare board of the county where placed is notified, but the chaplain keeps as close contact as possible. In fact, in all placements, even when active supervision is by the welfare board, some personal contact is kept by the chaplain, as well

as conferences held by him with the local social worker. Strict rules are set and must be held to. If, for any reason, the placement is unsatisfactory, the Annex sends for the man immediately.

At this time most of the men placed are on farms, but it is interesting to note the number of occupations open to us today needing no great degree of intelligence. The bureau of employment security recently analyzed job openings in 40 industries and reported that 47% of the jobs required no education beyond the ability to read and write. Two thirds of the jobs should be efficiently performed without any special vocational training. A minimum mental age of 6 was required for 19 types of jobs and a great number of jobs are adequately performed by persons with mental ages of 8 to 11.

We have only made a beginning in finding out what may be the potentialities for good adjustment of these men.

*Latter part summarized by Mildred Thomson

LEGISLATION AND ADDITIONAL FACILITIES NEEDED FOR THE MENTALLY DEFICIENT

Carl J. Jackson

The problem of caring for the mentally deficient continues to be serious. We are desperately in need of another institution. At this time there are nearly eight hundred cases that we have not been able to admit because of the lack of space. Many of these are urgent cases that really demand immediate institutionalization. In addition we are extremely overcrowded at Faribault. That institution is equipped to take care of approximately 2,200. The population at present is about 2,350.

As a temporary solution we would recommend the expansion of the Owatonna State School to care for five hundred. This can readily be done with the addition of two new double cottages to care for fifty boys or girls in each unit. The present capacity is four hundred.

There should be an additional cottage provided at Cambridge for the older patients.

In considering the needs of the institutions for the mentally deficient it is necessary to realize that many of their needs are the same as those of the state hospitals of other institutions. A part of what I shall say will apply to all of the institutions, but the needs of the state hospitals will be shown in more detail.

It is difficult to describe, especially in a brief talk, the many problems that have confronted our institutions in the war and postwar years. Inability to secure many materials and supplies, in the face of ever increasing prices, has greatly hampered the services of our institutions. There have been instances when we have not had sufficient bed sheets and pillow cases for patients' beds. Kitchen equipment, furniture and furnishings have deteriorated without possibility of replacement. It has been difficult to recruit personnel because of the attractive wages and conditions presented by private business and other ventures. The demand for nurses and doctors for Veterans Rehabilitation work has cut deeply into the complements of State institutions. These are but a few of the problems.

Although the Legislature appropriated funds far in excess of the previous biennium for current expense needs we were forced to draw upon our contingent fund and practically deplete it as of June thirtieth of this year. The rapid increase in the prices of food stuffs, clothing and other materials, coupled with a severe winter that greatly affected our expenditures for fuel are the reasons for the inadequacy of the current expense budget.

The shortage of doctors, nurses, dietitians and other professional personnel has continued throughout the past year with little prospect in sight for improved recruiting unless we can raise the salaries to meet the competition of the Veterans Hospitals and the incomes from private practice. It is apparent that we will have to institute more adequate training programs for the non-professional personnel if we hope to keep up proper standards of service and care.

Most hospitals and institutions are operating on a shorter work week. It is evident that if we are to attract desirable personnel we must be on a level with prevailing wage standards as well as conditions of employment.

We have a responsibility to fulfill in the care of our unfortunates. Failure to provide the services needed is a direct personal loss to the patient and a human and economic loss to the State.

The contemplated building program has also suffered due to increased costs. Although the Legislature considered its appropriations substantial enough to meet the costs of construction for the geriatric buildings at Fergus Falls, Moose Lake, Rochester and St. Peter, when bids were let we were far short. The State is proceeding with the building of one unit at each of the above mentioned hospitals. We are compelled to ask for supplemental appropriations in order to carry through the program. The same, no doubt, will be true for the receiving hospitals at Anoka, Hastings and Willmar. The lack of these facilities has naturally complicated our problem as we are greatly overcrowded and senile commitments continue to remain very high.

Minnesota provides seven state hospitals for the care of the mentally ill. They are Anoka State Hospital, Fergus Falls State Hospital, Hastings State Hospital, Moose Lake State Hospital, Rochester State Hospital, St. Peter State Hospital and Willmar State Hospital.

These hospitals are all seriously overcrowded, with a population of approximately 10,500. According to standards set up by the State Board of Health we have only an accepted bed capacity of 7,200. We are not only overcrowded, but many of our quarters and facilities are outmoded and obsolete. This is not a new situation but one that has existed for many years. Extensive repair is needed at practically all of these hospitals. With the exception of the Moose Lake State Hospital which was completed in 1938, most of them are forty to eighty years old. Roofs, brick work, gutters, plumbing, wiring, heating, water supply and other physical features, need attention. The State's capital investment in these hospitals represents a tremendous sum; therefore, it is important that they be kept in good repair. It is imperative that sufficient funds are supplied for upkeep. With the high cost of materials our regular repair funds have fallen far short of fulfilling the urgent needs that exist.

One of our greatest problems is that of food preparation and distribution. We have continually been adding to the capacity of our hospitals without expanding our kitchens, bakeries, dining rooms, food storage and other facilities. Much of the equipment is worn out or unsuitable for proper preparation. Very few pieces of equipment have the capacity adaptable for our needs. Careful attention must be given by the Legislature to the improvement of our foods program if we are going to provide the proper diets and meals for our patients and our staffs.

Our mental hospitals have come in for serious criticism during the past few months. Among the charges made, great stress was placed upon the food situation. It is apparent that if we are to correct this situation we must begin at the source which will require in several instances the complete renovation of our kitchens and bakeries, with the procurement of such equipment as is essential for proper preparation and distribution.

Other criticisms leveled at our hospitals include the lack of personnel. Our complements are insufficient both in the professional group as well as in the non-professional classifications. We have an inadequate number of doctors, nurses, dietitians, occupational therapists, psychologists, social workers, attendants, food service people and others. The charge is warranted as our ratio of staff to personnel is exceedingly inadequate. The standards of the American Psychiatric Association recommends a ratio of at least one staff member to every six patients. Our present ratio is one to 12 or 14. At present, on a 48 hour basis, it takes one employee to supply relief for three others. All employees are entitled to a day off per week, two weeks vacation leave, eleven holidays, plus time for illness. Therefore, to provide round the clock care, every day of the year, it takes four people for what constitutes a one person load. Therefore, with a ratio of one to six, one nurse or attendant will care for twenty-four patients. With our ratio today, one person on a shift must care for at least 48 patients. It is obvious that this is not sufficient, as many of these patients have to be clothed, bathed,

fed, and watched continuously. Certainly we cannot provide therapeutic work with such loads.

The American Association on Mental Deficiency, I am told, has a committee working on standards for the number of personnel needed for caring for the different types of patients. At present we do not have a definite yardstick, but for the helpless the number would not be much less than for the mentally ill--certainly many more than we now have. All institutions for the mentally deficient have in the past had brighter patients aid in the physical care of helpless patients. Minnesota wishes to have every person capable of making an adjustment back in the community. This means less patient help and thus more persons employed.

It was decided in the 1947 session of the Legislature that a central control system for all active tuberculosis cases would be established at Anoka. Eighty-six thousand dollars were appropriated to renovate the men's building. As in other instances this amount was too low. It will make at least \$350,000 to reconvert the building and an additional \$92,000 to provide the necessary equipment and furnishings. However, it is hoped that the Legislature will carry through with this program and provide adequate staffs so effective work may be done. We have at least three hundred active cases that should be properly isolated and treated. We cannot allow the present conditions to prevail, as it will only promote the problem of infections. Absorbing this building for the tuberculous patients will require some added facilities at the Anoka State Hospital. As a great deal of the food preparation is carried on in the men's building, as well as a great amount of food storage, it will be necessary to make other provision. Then, too, we will have to provide a sewage disposal plant as the Board of Health will object strenuously to the emptying of the sewage into the Rum River without proper treatment. This point is also very important and will require the attention of the Legislature.

One more feature must also be considered and this is the laundry from the tuberculosis building. An addition should be constructed to the present laundry building so appropriate handling can be facilitated.

To reduce the amount of mechanical restraint used in some of our hospitals it is imperative that we intensify and enlarge our recreational and occupational therapy in all of our hospitals. The Legislature voted funds in its last session to erect an occupational therapy building and auditorium at the Moose Lake Hospital. We are hopeful that the funds will be adequate so this building may be started this year.

Keeping patients active is the secret to non-restraint. Progressive hospitals are placing more and more emphasis upon activity and thus are able to reduce restraint. Activated programs, with trained personnel who have adopted a philosophy that patients can be cared for without the use of mechanical restraints will do a great deal to promote greater therapeutic treatment and provide a more humane handling of the patients.

Inventories at all of our hospitals are low. Furniture and furnishings are in need of replacement. Better quarters must be provided for staff as well as patients. More intensive treatment and carefully planned prolonged treatment must be provided to affect a higher percentage of cures.

While we do not expect "cures" of the mentally deficient, much of what applies to the mentally ill as regards programs involving greater activity will apply to the mentally deficient and also the epileptic in so far as better adjustment and the formation of better habits is concerned. Research is needed also to learn more of what can be done for certain groups of patients.

Emphasis has been put in a report to the Legislature on mental hospitals not only because of their needs, but also because of the interest of the Governor and his committee. I believe you will be interested in a list of objectives which comprise the program we wish to present to the Legislature for the betterment of the mental hospitals, not only because of interest in that program but also because most of them would also apply to Faribault and Cambridge and some even to Owatonna and the Annex for Defective Delinquents.. These are:

1. That the professional and non-professional staffs of all of the State hospitals be substantially increased.

Our hospitals are greatly understaffed. We have only one half of the complement recommended by the American Psychiatric Association. If patients are to receive complete physical, neurological and psychiatric examinations upon admission, if patients are to receive complete medical and surgical attention, if patients are to receive the best in intensive treatment for their mental illness, and if these patients who will be in need of prolonged care are to be provided with effective continued treatment, it is imperative that we increase the staffs of all of our mental hospitals so we may administer these services.

It must be remembered that many mental patients require a great deal of attention. Many need to be clothed, bathed, fed and helped about in addition to receiving the treatment and care their illness may require.

2. To attract this personnel our State must take definite steps to increase the salaries, so Minnesota will be in a position to successfully compete and recruit competent psychiatrists, doctors, nurses and other staff.
3. It is also important that adequate housing, attractive accommodations and satisfactory conditions of employment are provided.

Too often we are unable to attract interested applicants because our housing accommodations are unsuitable or entirely lacking. Then too, Minnesota institution workers are required to work 48 hours a week when many private and city hospitals are operating on a shorter work week.

4. All hospitals shall be active teaching hospitals.

Progressive doctors, nurses and hospital personnel wish to be associated with hospitals that have a fully activated program including research. Therefore, it is important that we maintain doctors, psychiatrists and nurses and other specialized staff who are qualified for teaching purposes. We wish to have our hospitals associated with the University medical school, the Mayo Clinic and our State colleges to offer opportunities in resident and interne training. Likewise we wish to have active teaching programs for our attendant and nursing personnel.

5. To provide inviting meals and better diets, according to the needs of the patient, it is recommended that several of the kitchens be completely renovated and that proper and adequate equipment be installed for the preparation and distribution of the food. Dietitians and sufficient supporting personnel must be provided to execute and facilitate our food programs. All hospitals are to prepare one menu so patients receive the same food as the employees.

6. Patients are to be comfortably dressed and attention given to the accommodations.

The inventories of our hospitals have suffered during the war and post war periods. Many items such as sheeting, yard goods, curtain material, bed spreads and dishes have been difficult to obtain. The same holds true for ward furniture and bedside equipment.

In building our inventories and strengthening our occupational therapy and our industrial shops, we can do a great deal to add to the comfort of our patients. Canteens should be provided to permit patients to purchase confections, fruit and ice cream.

7. Active tuberculosis cases must be removed to a central control hospital where proper treatment and isolation may be provided. It is recommended that the Division of Public Institutions be given Funds to provide such a facility, equipped with the medical needs to provide surgery and treatment for tuberculosis cases.
8. It is also recommended that the Division be given a contingency of \$50,000 annually to conduct research. This fund may be allocated for research and the introduction of new techniques and drugs as the Director and his medical staff may direct.
9. A well organized system of social service is recommended to assist the medical staff in obtaining case histories and also to assist patients in placement and after care. We believe that quite a number of patients could be prepared for placement if we had a sufficient number of social workers.
10. Out-patient clinics operating at each hospital shall be provided to give aid to the paroled patients and also to provide assistance to the doctors, social workers and judges who may have clients that need observation and diagnosis. Such a procedure will provide a better screening on admissions and will obviate the necessity of institutionalization in many cases. We have to be concerned about the preventive measure in this problem.
11. Additional psychiatric staff in the central office shall be provided to give assistance to the correctional institutions.

Frequently the wardens and superintendents request this service. From time to time the Board of Parole also requests the examination and observation of inmates.

12. In order to provide spiritual guidance and counseling, it is recommended that resident chaplains, who have had some clinical training, shall be appointed at all hospitals.
13. The Legislature is urged to grant additional funds so that the program of erecting geriatric buildings at St. Peter, Rochester, Moose Lake and Fergus Falls may be carried to completion. The same holds true for the receiving hospitals that were planned for Anoka, Hastings and Wilmar. Funds appropriated in 1947 have not been sufficient due to the increased building costs.

I wish now to again speak more specifically of what should be done for the mentally deficient and epileptic. They present many problems other than those related to institutional care. There are medical, psychiatric, psychological, social,

and educational aspects to be considered in establishing policies or procedures or in recommending the passage of laws. It seems the time may have come when all phases of the care, training, and supervision of the mentally deficient should be considered together and one integrated plan made. The same should be done for the epileptic. Research should be initiated where it appears there is still insufficient knowledge to know what may be needed.

This would mean careful consideration of legal aspects. Also, with the higher grade mentally deficient and the physically competent epileptic the question would be raised of the emphasis to be put on employment possibilities and the relations to labor and industry.

Recommendation is, therefore, to be made to the Legislative that a commission be established to study the problems involved and present a comprehensive and integrated plan not only involving changes in laws but necessary facilities to carry out recommended procedures. It would appear that this should be composed not only of representatives of the several divisions or departments of the state responsible for carrying out the provisions of the law but of representatives of relevant schools or departments of the University. Also persons from professional organizations and agencies, whose knowledge of the subject and of trends in other states would make possible comprehensive discussion and the establishment of objectives for immediate and longtime fulfillment, should be placed on the commission.

In view of the fact that this recommendation is being made for a study of all problems related to the mentally deficient, the Division will make no recommendations of other changes in the law except minor ones. The Legislature will be asked to change the name of the institution at Faribault in order to leave out the term "feeble-minded". It may be that a similar change in the name of the institution at Cambridge should be given consideration.

Due to the Supreme Court decision regarding the legality of commitments to state guardianship where the petition was filed by the parent, there will have to be some legislation relative to the status of the many wards--probably five thousand or more--who come within this category. The judges of the Probate Court are interested in this problem and will cooperate in determining just what legislation may be necessary.

It is my hope also that the work of the Bureau for the Mentally Deficient and Epileptic may be more helpful to you in the future than it has been able to be in the past. A request will be made for a sufficient appropriation to give you increased service from social workers. This will make it possible for you to have a worker come to your county when there is a situation upon which you would like advice and some assistance. Also, when you first begin working with the mentally deficient you may wish some general advice "on the job" as to the policies and procedures that you should follow. We wish to cooperate with you so as to make service to the mentally deficient in Minnesota the very best possible.